1

12732

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

12767

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| NETTIE | ELEANOR | BARNES | August 28, 1970 | M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN |
|---|---|---|---|---|---|
| Female | White | Jan. 15, 1884 | 86 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| Maryland | U.S.A. | | WORCESTER Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Pocomoke City | 6 Second Street | none | -- |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Maryland | Worcester | Pocomoke | | 6 Second Street |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| Francis | James | Barnes | Emily | -- | Langford |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|---|
| no | -- | unk | Mrs Lucy Tull, Salisbury, Maryland |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Coronary Occlusion | Minutes |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Coronary Artery Disease | Years |
| DUE TO, OR AS A CONSEQUENCE OF (c) | Hypertensive Cardio Vascular | Years |

4100

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Bronchiectasis; Emphysema; Chronic Nephritis; Old Myocardial Infarction

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (~~this hospital~~) attended the deceased from Oct. 10, 1962, to Aug. 28, 1970, that (I) (~~we~~) last saw the deceased alive on Aug. 28, 1970, and that in (my) (~~our~~) opinion death occurred on the date and haur and from the causes stated above, (I) (~~we~~) (did) (~~did not~~) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| Charles W. Trader | MD | ☒ | ☐ | ☐ | Aug. 30, 1970 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| Charles W. Trader, M.D., | 302 Market St., Pocomoke City, Md. |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 8-30-1970 | Pitts Creek Presbyterian | Pocomoke City-Wor.-Md. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Robert N. Watson | Pocomoke City, Md. | SEP 3 1970 | J. Charles Judge |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 45M - 1/69

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12733

12768

## CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. **PLACE OF DEATH**
   a. COUNTY: Worcester — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ocean City, Md.
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Ocean City, Md.

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Worcester
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ocean City, Maryland
   d. STREET ADDRESS: Box 55
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Elizabeth — Middle: L. — Last: Eckhart

4. **DATE OF DEATH**: Month: 8/3 — Doy — Year: 19 70

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☒ — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐

8. DATE OF BIRTH: Aug. 9, 1904

9. AGE (In years last birthday): 65 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Abington, Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robert Lane

14. MOTHER'S MAIDEN NAME: Sarah Hockett

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 219-36-2444

17. **INFORMANT** — Address: Ellwood Eckhart Merrymans Mill Rd. Pheonix 21131

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Arrest — INTERVAL BETWEEN ONSET AND DEATH: 12:30
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Acute Myocardial I — 1:05
DUE TO
(c): Coronary insufficiency — 3 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from 1967, 19___, to Aug 3, 1970, that (I) (we) last saw the deceased alive on Aug 3 1970, and that death occurred at ___M, from causes and on the date stated above.

22a. SIGNATURE: F. J. Townsend, Jr. M.D. — ATTENDING PHYS. ☐ — MED. DIRECTOR ☐ — STAFF PHYS. ☐

22b. DATE SIGNED: 8/3/70

22c. PHYSICIAN'S NAME (Type): Francis J. Townsend, Jr., M.D

22d. ADDRESS: Ocean City, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Aug. 6, 1970

23c. NAME OF CEMETERY OR CREMATORY: Fork Methodist Cemetery

23d. LOCATION (City or Town) (County) (State): Fork — Harford — Md.

24. FUNERAL DIRECTOR — ADDRESS: Lassahn Funeral Home 7401 Belair Rd. 21236

25a. REC'D BY REGISTRAR — DATE: AUG 6 1970

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12734 12769

# CERTIFICATE OF DEATH

| 1. DECEASED-NAME (Type or print) First | Middle | Lost | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| Thomas | Vincent | Grey | Aug 31 1970 | 9P M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN |
|---|---|---|---|---|---|
| Male | White | Sept. 28, 1888 | 81 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| Maryland | U.S.A. | | Worcester Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street oddress) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Snow Hill | Rt. 1 | Waterman | Seafood |

| 13a. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES ☐ NO ☑ | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Maryland | Worcester | Snow Hill | | |

| 14. FATHER'S NAME First | Middle | Lost | 15. MOTHER'S MAIDEN NAME First | Middle | Lost |
|---|---|---|---|---|---|
| Thomas | Jefferson | Grey | Harriet | | Taylor |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|
| No | 218349666 | Mrs. Frances E. Grey, Snow Hill, Md. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | MYOCARDIAL FAILURE | 2 HR |
| DUE TO, OR AS A CONSEQUENCE OF (b) | ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE | 15 YRS |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

4124
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE ORCONDITION GIVEN IN PART 1(a)
EMPHYSEMA (PULMONARY) CEREBRAL VASCULAR ACCIDENT 1968

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol exominer) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Yeor 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. I **certify** that (I) (this haspital) attended the deceased from Oct, 1963, to Aug, 1970, thot (I) (~~we~~) last saw the deceased alive an Aug 20 1970, and that in (my) (~~our~~) opinion death accurred an the date and haur and from the causes stated above. (I) (~~we~~) (~~did~~) (did nat) view the body after deoth.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. ☒ | MED. DIRECTOR ☐ | STAFF PHYS. ☐ | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| Robert C. La Mar | | | | | 9-3-70 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| Robert C. La Mar, M.D. | 104 Bay St, Snow Hill, Md. |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY ~~OR CREMATORY~~ | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | Sept. 4, 1970 | Bates Methodist | Snow Hill Maryland |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Norman F. Fleming | Snow Hill, Md. | SEP 8 1970 | J. Charles Judge |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the haspital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

Item 4 Film G427
8/24/70 lwc

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12770

1 FOR STATE HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

12735

1. DECEASED NAME (Type or Print): First JAMES Middle JOSEPH Last KIRWIN III
2a. DATE OF DEATH KNOWN ☐ ESTIMATED ☐ Month 8 Day 16 Year 1970
2b. HOUR 2:15 P.M.
2c. DATE PRONOUNCED DEAD Month 8 Day 16 Year 1970
2d. HOUR 2:15 P.M.
3. SEX M
4. RACE White
5. DATE OF BIRTH 2-19-28
6. AGE (In years last birthday) 42 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country) N.Y.
7b. CITIZEN OF WHAT COUNTRY? USA
8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
9. COUNTY OF DEATH WORCESTER Md.
10. CITY OR TOWN OF DEATH Ocean City
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1001 Philadelphia Ave
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Mrg. Am. Security Fireset
12b. KIND OF BUSINESS OR INDUSTRY Banking
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.
13b. COUNTY Montgomery
13c. CITY OR TOWN Wheaton
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET AND NUMBER 2606 Henderson Ave 4260 DECATUR AVE.
14. FATHER'S NAME First JAMES Middle JOSEPH Last KIRWAN
15. MOTHER'S MAIDEN NAME First AGNES Middle BYRNE Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service)
16b. SOCIAL SECURITY NO. 076-22-9301
17. INFORMANT Patricia S. Kirwin ADDRESS Same as #13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 30 minutes
DUE TO, OR AS A CONSEQUENCE OF (b) ASAD — unknown
DUE TO, OR AS A CONSEQUENCE OF (c)
4109
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
None

19a. DATE OF OPERATION 0
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 0
20. AUTOPSY? YES ☐ NO ☐
21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH NA
21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) NA
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE M Carter M.D.
EXAMINER'S NAME (Type)
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
ADDRESS (Street, city, town, or county)
22b. DATE SIGNED 8-16-70

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 8-19-70
23c. NAME OF CEMETERY OR CREMATORY Baltimore National
23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Francis J. Collins ADDRESS 500 University Blvd. W., Silver Spring, Md.
25a. REC'D BY REGISTRAR DATE AUG 19 1970
25b. REGISTRAR'S SIGNATURE J Charles Judge

3702

VR A15ME (5) 10M REV. 1/68

Item 18 Film 429 10/2

MARYLAND STATE DEPARTMENT OF HEALTH

FOR STATE HEALTH DEPT.

12736

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12771

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in part II in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or Print) | First: Thomas | Middle: F. | Last: Lee | | | | | 2a. DATE OF DEATH: KNOWN ☒ ESTIMATED ☐ | Month: 8 | Day: 24 | Year: 1970 | 2b. HOUR: 8 A M |
| 3. SEX: M | 4. RACE: W | 5. DATE OF BIRTH: JUNE 7 1912 | 6. AGE (In years last birthday): 58 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | | | 2c. DATE PRONOUNCED DEAD | Month: AUG | Day: 24 | Year: 1970 | 2d. HOUR: 8 15 AM |
| 7a. BIRTHPLACE (State or foreign country): PENN. | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH: Worcester Md. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH: Ocean City | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): 1001 Phila. Ave | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Pipefitter Gen. TRANSFER FOREMAN | 12b. KIND OF BUSINESS OR INDUSTRY: PLUMBING CONTRACTOR | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: PA | 13b. COUNTY: DEL CO | 13c. CITY OR TOWN: E. LANSDOWNE | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET AND NUMBER: 207 Bayview Ave. | | | | | | | | |
| 14. FATHER'S NAME: First: THOMAS | Middle: S. | Last: LEE | 15. MOTHER'S MAIDEN NAME: First: LOUISE | Middle: AMANDA | Last: SCHUSTER | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): UNK | (If yes give war or dates of service): No | 16b. SOCIAL SECURITY NO. | 17. INFORMANT: Mrs. T. F. LEE | ADDRESS: 209 BAYVIEW AVE E LANSDOWNE PA. | | | | | | | | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease — Ventricular Fibrillation — Cardiopulmonary Arrest

DUE TO, OR AS A CONSEQUENCE OF

(b): Occlusion of Coronary Artery

DUE TO, OR AS A CONSEQUENCE OF

(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: IMMED

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES ☒ NO ☐ |
|---|---|---|
| | | |

| 21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: J. V. Russo M.D.

EXAMINER'S NAME (Type): J. V. Russo, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
ADDRESS (Street, city, town, or county)

22b. DATE SIGNED: 8-24-70

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| BURIAL | 8/27/70 | Holy Cross | VERNON DEL PA. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE AUG 26 1970 | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Anna A. Burbage | Berlin Md | | J. Charles Judge |

VR A15ME (5) 8M-1/70

1
FOR STATE HEALTH DEPT.

12737

Items#7a,b,8,24,FilmG430 11/10/70 kam

Item #23 Film #G430 11/16/70ps

12772

# MARYLAND STATE DEPARTMENT OF HEALTH
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| 1. DECEASED-NAME (Type or Print) First | Middle | Last | 2a. DATE KNOWN OF DEATH ESTIMATED | Month | Day | Year | 2b. HOUR |
|---|---|---|---|---|---|---|---|
| Robert | Luis | Lopez | ☒ | 8 | 2 | 1970 | 2:15 P.M. |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS | IF UNDER 1 YEAR DAYS | IF UNDER 24 HRS HOURS | IF UNDER 24 HRS MIN | 2c. DATE PRONOUNCED DEAD Month | Day | Year | 2d. HOUR |
|---|---|---|---|---|---|---|---|---|---|---|---|
| male | White | | 43 YRS. | | | | | 8 | 2 | 1970 | 2:15 P.M. |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| Unknown | Unknown | Unknown | Worcester Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Ocean City | Ocean City, Maryland | | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Md. | Worcester | Silver Spring | YES ☐ NO ☒ | 710 Roeder Road |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| | | | | | |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | | |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Gunshot wound of head
955 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? |
|---|---|---|
| | | YES ☒ NO ☐ |

| 21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. ? P.M. ? 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | Subject shot himself in head |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | Car | | Ocean City | Worcester | Md. |

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE _____ M.D.

EXAMINER'S NAME (Type) Peter Lipkovic, M.D.
Associate Medical Examiner

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
ADDRESS (Street, city, town, or county)

22b. DATE SIGNED 8/3/70

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| | Aug. 3, 1970 | Health Dept. Anatomy Board | - Nov. 5, 1970 |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Baltimore City Health Dept. (Morgue) | AUG 20 1970 | Charles Judge |

**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MD. 21201**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

REMAINS STILL AT MEDICAL EXAMINER OFFICE 8/18/70

2500 VR A15ME (5) 10M - 1/69

3

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

12738

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12773

| | | | |
|---|---|---|---|
| 1. DECEASED-NAME (Type or Print) First: FLOYD Middle: EVERETT Last: MASTERS | 2a. DATE OF DEATH KNOWN ☐ ESTIMATED ☐ Month 8 Day 19 Year 1970 | 2b. HOUR Unknown M | |
| 3. SEX: M | 4. RACE: W | 5. DATE OF BIRTH: DEC. 11 1909 | 6. AGE (In years last birthday) 60 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN |
| 2c. DATE PRONOUNCED DEAD Month Day 8 - 19 Year 1970 | 2d. HOUR 10 AM | | |
| 7a. BIRTHPLACE (State or foreign country): INDIANA | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH: Worcester Md. |
| 10. CITY OR TOWN OF DEATH: BERLIN | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): — | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): FARMER | 12b. KIND OF BUSINESS OR INDUSTRY: SELF EMP. |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND | 13b. COUNTY: WOR. | 13c. CITY OR TOWN: BERLIN | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ |
| 13e. STREET AND NUMBER: RT #2 - Berlin | | | |
| 14. FATHER'S NAME First: HENRY Middle: F Last: MASTERS | 15. MOTHER'S MAIDEN NAME First: SARAH Middle: EUZABETH Last: CARR | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service) NO | 16b. SOCIAL SECURITY NO. | 17. INFORMANT: MR. ROBERT MASTERS ADDRESS: BATTLEGROUND IND. | |

MEDICAL CERTIFICATION

1B. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Gunshot Wound of Head — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Instantaneous

955X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES ☒ NO ☐ |
| 21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. City or Town County State |

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE [signature] M.D.

EXAMINER'S NAME (Type)

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

ADDRESS (Street, city, town, or county)

22b. DATE SIGNED 8-19-70

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL | 23b. DATE: 8/22/70 | 23c. NAME OF CEMETERY OR CREMATORY: RIVERSIDE | 23d. LOCATION (City or Town) BERLIN (County) WOR (State) RFD MD |
| 24. FUNERAL DIRECTOR: Anna A. Burbage ADDRESS: Berlin Md | 25a. REC'D BY REGISTRAR DATE: AUG 25 1970 | 25b. REGISTRAR'S SIGNATURE: J Charles Judge | |

**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

M 00 23 1

VR A15ME (5) 10M - 1/69

12739

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12774

# CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month | Day | Year | 2b. HOUR |
|---|---|---|---|---|---|---|
| JEWELL | L | MATTHEWS | AUGUST | 1st | 1970 | 12:30 P.M. |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS HOURS / MIN |
|---|---|---|---|---|---|
| FEMALE | WHITE | SEPTEMBER 5, 1889 | 80 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| ACCOMACK, Co | U.S.A | WIDOWED [X] | WORCESTER Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| POCOMOKE CITY | 1605 CEDAR ST | HOUSEWIFE | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | WORCESTER | POCOMOKE | YES [X] NO [ ] | 1605 CEDAR STREET |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| GEORGE THOMAS | | LITTLETON | MARY EMILY | | PHILLIPS |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|---|
| NO | — | 219-36-6054B | MISS MARY EMILY MATTHEWS | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Metastatic Carcinoma, generalized | 3 years |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Carcinoma of the left breast | 3 years |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 174X

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES / NO | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | NO [X] | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) |
|---|---|---|

| 21d. INJURY OCCURRED While at work / Not while at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (~~this hospital~~) attended the deceased from August 8, 1967, to August 1, 1970, that (I) (we) last saw the deceased alive on August 1, 1970, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (~~did not~~) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| Charles W Trader | MD | [X] | [ ] | [ ] | 8/3/70 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| Charles W. Trader, M.D. | Pocomoke City, Maryland. |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| BURIAL | AUGUST 4-1970 | NELSON CEMETERY | ACCOMACK COUNTY Va |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. RECD. BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Henry H. Dalton | Pocomoke Md. | AUG 5 1970 | Josiah S. Judge |

VR A15 (4)
45M - 1/69

1

**FOR STATE HEALTH DEPT.**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours of death. Any deloy is necessory, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

12740

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12775

| 1. DECEASED-NAME (Type or Print) First | Middle | Last | 2a. DATE KNOWN OF ESTIMATED ☑ Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| John | Hoyt | McIntyre | Aug 16 1970 | 6P M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 2c. DATE PRONOUNCED DEAD Month Day Year | 2d. HOUR |
|---|---|---|---|---|---|---|---|
| Male | White | Jan. 24, 1903 | 67 YRS. | | | Aug 16 1970 | 6P M |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| Maryland | U.S.A. | | Worcester Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Snow Hill | 213 E. Martin St. | Retired Laber | Town of Snow Hill |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Maryland | Worcester | Snow Hill | YES ☑ NO ☐ | 215 E. Martin St. |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| Rise | | McIntyre | Judy | | Unknown |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| | 218 05 8547 | Thelma Gardner, Falls Church, Va. |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) ACUTE CORONARY OCCLUSION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 30 MIN

DUE TO, OR AS A CONSEQUENCE OF

(b) A.S.H.D. — UNKNOWN

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause last. 4109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Robert C. La Mar M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED 8-19-70

EXAMINER'S NAME (Type) Robert C. La Mar, M.D. ADDRESS (Street, City, or County) 104 Bay St, Snow Hill, Md. Worcester co.

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY ~~OR CREMATORY~~ | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | Aug 20, 1970 | Olivet | Snow Hill Worcester, Md. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Herman L. Lemmon, Snow Hill, Md. | AUG 24 1970 | Charles Judge |

VR A15ME (5) 10M REV. 1/68

Items 18,20,21b,22a
Film 428 9/22/70 mh

**MARYLAND STATE DEPARTMENT OF HEALTH**

12741

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12776

**1 FOR STATE HEALTH DEPT.**

**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MA 1A3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or Print) First / Middle / Last | Joseph Tassallo | | | | | 2a. DATE KNOWN OF DEATH / ESTIMATED: Month 8 Day 6 Year 70 | 2b. HOUR 3:05 P |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS: HOURS / MIN. | 2c. DATE PRONOUNCED DEAD: Month 8 Day 6 Year 1970 | 2d. HOUR 3:05 M |
| M | W | 1/15/29 | 41 YRS. | | | | |
| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH | | | | |
| E.St.Louis,Ill | U.S. | | Worcester Md. | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Ocean City | 1001 Philadelphia Ave | Systems Analysis | Social Sec. | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER | | | |
| 1233 Stellar Dr. | Balto | Balt. | YES ☐ NO ☑ | | | | |
| 14. FATHER'S NAME First / Middle / Last | | 15. MOTHER'S MAIDEN NAME First / Middle / Last | | | | | |
| Vito Tassallo | | Louise Vitalli | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS | | | | |
| Yes 1-19-51 to 1-3-57 | 33-20-3339 | Wife | 1233 Stella Drive 21207 | | | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Occlusion of Coronary Arteries

DUE TO, OR AS A CONSEQUENCE OF

(b) Arteriosclerotic Heart Disease

DUE TO, OR AS A CONSEQUENCE OF

(c)

4109

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? |
|---|---|---|
| | | YES ☒ NO ☐ |

| 21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. | 21c. HOW INJURY OCCURRED (Enter noture of injury in Part I or Part 2, Item 18.) |
|---|---|---|
| | 8/6/ 2:15 19 70 | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State |
|---|---|---|
| | | |

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☑, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Ralph O. DeFronzo, M.D. M.D.

EXAMINER'S NAME (Type) Ralph De Fronzo, M.D,

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑

ADDRESS(Street, city, town, or county)

22b. DATE SIGNED

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | Aug. 10-70 | Baltimore Natioanl | Frederick Rd. Balto.Md |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Edw.S.MacNabb | 301 Frederick Rd.21228 | AUG 11 1970 | Charles Judge |

VR A1SME (5)
10M - 1/69

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FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

12742

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12777

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MD. 21201

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give reasons in Item 27. Page 2 should be forwarded to the Chief Medical Examiner's Office along with Form PM2. Page 1 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or Print) First | Middle | Last | 2a. DATE KNOWN OF DEATH ESTIMATED | Month | Day | Year | 2b. HOUR |
| Richard | WILLIAM | Tobin | ☒ ☐ | 8 | 2 | 19 70 | 1145 M |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS: HOURS / MIN. | 2c. DATE PRONOUNCED DEAD | 2d. HOUR |
| MALE | WHITE | 2/26/27 | 43 YRS. | | | Month 8 Day 2 Year 19 70 | 1300 M |

| | | | | |
|---|---|---|---|---|
| 7a. BIRTHPLACE (State or foreign country) NEW JERSEY | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH WORCESTER Md. | |
| 10. CITY OR TOWN OF DEATH OCEAN CITY | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ATLANTIC OCEAN | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) GENERAL SURGEON | 12b. KIND OF BUSINESS OR INDUSTRY SURGERY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE DELAWARE | 13b. COUNTY SUSSEX | 13c. CITY OR TOWN SEAFORD | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET AND NUMBER 607 NYLON BLVD. |

| | | | |
|---|---|---|---|
| 14. FATHER'S NAME First / Middle / Last | 15. MOTHER'S MAIDEN NAME First / Middle / Last | | |
| JOHN CLARKE | WILLIAM TOBIN | GRETCHEN KRUEGER | TOBIN |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes give war or dates of service) WAR II | 16b. SOCIAL SECURITY NO. 221-30-5640 | 17. INFORMANT ADDRESS JUDITH G. TOBIN - SEAFORD DEL. | |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Thrombosis Myocardial Infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 30-45m Tic
DUE TO, OR AS A CONSEQUENCE OF
4109
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES ☒ NO ☐ |
| 21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (At home, form, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State |

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE [signature] M.D.

EXAMINER'S NAME (Type) Hunter R. Mann, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ADDRESS (Street, city, town, or county)

22b. DATE SIGNED 8-2-70

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE AUG 5, 1970 | 23c. NAME OF CEMETERY OR CREMATORY ODD FELLOWS Cem. | 23d. LOCATION (City or Town) (County) (State) SEAFORD SUSSEX DEL. | |
| 24. FUNERAL DIRECTOR Paynter M. Watson | ADDRESS SEAFORD DEL. | 25a. REC'D BY REGISTRAR DATE AUG 6 1970 | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | |

VR A15ME (5)
10M - 1/69

over

Signature of M.E. verified with Dr. Townsend's secretary per tele. conv. 9/1/70 jcp
Dr. Mann is substituting for Dr. Townsend.

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**FOR STATE HEALTH DEPT.**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Item#6,
FilmG428 9/2/70 km

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12778

12743

| | | | |
|---|---|---|---|
| 1. DECEASED NAME (Type or Print) First: James Middle: Edward Last: Weldon | 2a. DATE OF DEATH KNOWN ☐ ESTIMATED ☐ Month 8 Day 17 Year 70 | 2b. HOUR 7 A.M. | |
| 3. SEX: M | 4. RACE: W | 5. DATE OF BIRTH: 12-5-80 | 6. AGE (In years last birthday) 89 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN. |
| 2c. DATE PRONOUNCED DEAD Month 8 Day 17 Year 70 | 2d. HOUR 8 P.M. | | |
| 7a. BIRTHPLACE (State or foreign country): USA (MD) | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH: Worcester Md. |
| 10. CITY OR TOWN OF DEATH: Bishopville | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): — | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Painter | 12b. KIND OF BUSINESS OR INDUSTRY: Self Employed |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MD. | 13b. COUNTY: Worcester | 13c. CITY OR TOWN: Bishopville | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ |
| 13e. STREET AND NUMBER: RT #1 | | | |
| 14. FATHER'S NAME First: James Middle: T. Lost: Weldon | 15. MOTHER'S MAIDEN NAME First: Hester Middle: Gray Lost: | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service) — | 16b. SOCIAL SECURITY NO. 215-38-1556 | 17. INFORMANT SADIE WELDON Wife ADDRESS BISHOPVILLE Same Md. | |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

4369

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Cerebro-Vascular Accident | Instant |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Generalized Arteriosclerosis | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | |
|---|---|---|
| 19a. DATE OF OPERATION — | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — | 20. AUTOPSY? YES ☐ NO ☒ |
| 21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) — |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or ~~R.F.D. No.~~ City or Town County State |

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE H. E. R. M[illegible] M.D.

EXAMINER'S NAME (Type)

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
ADDRESS (Street, city, town, or county)

22b. DATE SIGNED 8-17-70

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL | 23b. DATE: 8-19-70 | 23c. NAME OF CEMETERY OR CREMATORY: Odd Fellows | 23d. LOCATION (City or Town) (County) (State): Bishopville Worcester, Md. |
| 24. FUNERAL DIRECTOR: Peter Whaley | ADDRESS: Silbyville Del. | 25a. REC'D BY REGISTRAR DATE: AUG 20 1970 | 25b. REGISTRAR'S SIGNATURE: J Charles Judge |

VR A15ME (5)
10M REV. 1/68

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12744

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

12779

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month | Day | Year | 2b. HOUR |
|---|---|---|---|---|---|---|
| Horace | H. | Willey | Aug. | 21 | 1970 | 9:30 AM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS: HOURS / MIN |
|---|---|---|---|---|---|
| Male | White | April 14, 1896 | 74 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| Delaware | USA | MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | Worcester Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Selbyville | At home | Farmer | Own Farm |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES / NO | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Maryland | Worcester | Selbyville | YES [ ] NO [X] | RFD # 2 |

| 14. FATHER'S NAME First Middle Last | 15. MOTHER'S MAIDEN NAME First Middle Last |
|---|---|
| Ambrose Willey | Anna Tucker |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|---|
| xx | xx | 222-05-5217 | Alice Willey Selbyville, Del. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) metastatic carcinoma — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 4 mos ?
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Emphysema

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES / NO | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| 5-5-70 abdl 5-21-70 Abdl | Frank D. Hospital Co | YES [ ] NO [X] | Yes Findings at Autopsy |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work / Not while at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this hospital) attended the deceased from 1965, 19____, to 8-21-70, 19____, that (I) (we) last saw the deceased alive on 8-21-70 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| Frank Lewis M.D. | | [X] | [ ] | [ ] | 8-24-70 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| Frank Lewis | Willards Maryland |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| | 8/24/70 | Odd Fellows | Highlevyville Worcester Md. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Peter Whaley | Selbyville Del. | AUG 27 1970 | J. Charles Judge |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69